SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
Company Tracking Number:	*03L10110*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Level Term Application	SERFF Tr Num: SHLI-126754984	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46397
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: 03L10110	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Dina Krofta, Berdetta Moore	Disposition Date: 08/09/2010
	Date Submitted: 08/04/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: E-app
Project Number: L10110
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/09/2010

Deemer Date:
Submitted By: Berdetta Moore
Filing Description:
e-app

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/09/2010
Created By: Berdetta Moore
Corresponding Filing Tracking Number: L10110

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative — blmoore@shelterinsurance.com

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
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Project Name/Number:	*E-app/L10110*		

Assistant
1817 W. Broadway
Columbia, MO 65203
573-214-4832 [Phone]
573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company	CoCode: 65757	State of Domicile: Missouri
1817 W. Broadway Street	Group Code: 123	Company Type: Life and Health
Columbia, MO 65203	Group Name:	State ID Number:
(800) 743-5837 ext. [Phone]	FEIN Number: 43-0740882	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	$50.00	08/04/2010	38518770

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
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Project Name/Number:	*E-app/L10110*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/09/2010	08/09/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Description and Drop Down Answers	Note To Reviewer	Berdetta Moore	08/06/2010	08/06/2010
Description	Note To Reviewer	Berdetta Moore	08/04/2010	08/04/2010

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
Company Tracking Number:	*03L10110*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Disposition

Disposition Date: 08/09/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
Company Tracking Number:	*03L10110*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Individual Life Insurance Application		Yes

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Note To Reviewer

Created By:

Berdetta Moore on 08/06/2010 09:31 AM

Last Edited By:

Linda Bird

Submitted On:

08/09/2010 01:02 PM

Subject:

Description and Drop Down Answers

Comments:

This application is intended to be used as an electronic application.

Term

Question Number	Question Description	Additional questions generated by a yes answer	Drop-down options	Misc. Notes
--	Agent Name, Agent #, Agent Phone #, Family #	none	none	For internal use only Family numbers are variable and will be assigned by the Home Office
--	Application Number	none	none	The application number will appear at the top of each page of the application. This number will differ for each application and will be assigned by the Home Office.
--	Relationship	if "Other" selected, will provide a text box for description	Applicant Spouse Child Parent Sibling Other	same drop-down options for each party to contract (insured, owner, payor, primary and contingent beneficiaries, successor owner, custodian)
1	Gender	none	Male/Female	
1	Marital Status	none	Single Married Separated Divorced Widowed	
3 and 3a	State	none	List of all 50 states	
3 and 3a	County	none	List of applicable counties based on state selection	
3a	Mailing Address	none	none	Will populate with the physical address unless the applicant chooses a different mailing address.
6	Citizenship	if US Citizen? = no, will ask for country of citizenship, length of residency in the US, and visa type; if visa type = temporary, then display visa category	Visa type: Permanent, temporary	
9	Plan	none	10 Year Level Term to 100 20 Year Level Term to 100 30 Year Level Term to 100 YRT to 85	
9	Rate class	none	If Level Term selected: Ultra Preferred Non-Tobacco, Preferred Non-Tobacco, Non-Tobacco, Preferred Tobacco, Tobacco If YRT to 85 selected: Preferred Non-Tobacco, Standard Non-Tobacco, Standard	
10	Waiver of Premium	none	Yes/No	Answer will print as either "included" or "not included"
10	Accidental Death	Amount of AD desired	Yes/No	Answer will print as either "included" or "not included"

11	Mode of Premium	Details field if PAC, Special Billing, or Payroll Deduction selected	Annual, Semi-Annual, Quarterly, PAC (Pre-Authorized Check), Special Billing, Government Allotment, Payroll Deduction	Details will print at question #11a; this question will not appear if there are no remarks
12	Beneficiary	if "unequal shares" selected, display box for percent of proceeds to each named beneficiary if "other" selected, display text box for instructions	Equally or to Survivor(s) Equally Per Stirpes Equally Per Capita Unequally Other	options appear for both primary and contingent beneficiaries
12	Contingent Beneficiary	none	none	If none selected, will print "none" on the application.
12	Payor	none	none	If no alternate payor is selected, will print "same as Insured" on application.
12	Owner	none	none	If the applicant is owning his/her own policy, we will print "same as Insured" on the application.
12	Successor Owner	none	none	If none, will print "none" on the application.
13a	Amount of insurance on siblings	Appropriate number of boxes based on number of siblings	none	We will ask how many siblings the applicant has on the system; it will print out the correct number of boxes on the application. This question only appears if the applicant is age 15 or younger.
14	Replacement	Company drop-down*, company name, policy number, face amount, reason for replacement	*Shelter or other; if other, then will provide text box for name of company	info from this question will also populate the replacement form
15	Have you seen a doctor	Consultation date, consultation reason, was a diagnosis made, diagnosis explanation (if diagnosis made = yes), was treatment prescribed, treatment explanation (if treatment prescribed = yes), were medications prescribed, medications explanation (if medication = yes)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	can enter more than one doctor and/or consultation
16	Family hx disease	Relationship to insured, Explanation	Relationship: parent, sibling	
17	Family hx death	Relationship to insured, Age, Cause of Death	Relationship: parent, sibling	
18a	Aviation/ultralight flying/hang gliding/parachute jumping	if yes, will force completion of the Aviation Questionnaire (aviation/ultralights) or Hazardous Sports Questionnaire (sky diving/parachute jumping)		
18b	Hazardous Sports	if yes, will force completion of the Hazardous Sports Questionnaire		
24	Heart Disease	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	

25	Cancer/tumor	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
26	Respiratory Disease	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
27	Mental/Nervous Disorder	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
28	Brain/Nervous System	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
29	Diabetes/Glandular	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
30	Bones/muscles/joints	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
31	Digestive system	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
32	Kidney/bladder/prostate	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
33	AIDS/immune disease	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
34	Pregnancy	Approx. delivery date, describe illness, physicians(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
35	Receiving treatment	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
36	Weight loss	Date, # pounds lost, reason/details, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
37	Drug use	Date, length of use, amount, frequency, drug type(s), details, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
38	Alcohol	Date of last drink, amount, frequency, alcohol type(s), details, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
39	Drug/alcohol treatment	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	

40	Disability	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	
41	Other	Date, duration, describe illness, physician(s)	Date: Within last week, within last month, within last 6 months, within last year, more than a year ago	

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Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Note To Reviewer

Created By:

Berdetta Moore on 08/04/2010 02:21 PM

Last Edited By:

Linda Bird

Submitted On:

08/09/2010 01:02 PM

Subject:

Description

Comments:

I inadvertently forgot to fill in the filing description. We will be sending it shortly. Sorry, for the mix up. Thanks!

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
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Project Name/Number:	*E-app/L10110*		

Form Schedule

Lead Form Number: L-953

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-953	Application/ Enrollment Form	Individual Life Insurance Application	Initial		51.200	L-953.pdf

SHELTER LIFE INSURANCE COMPANY

1817 West Broadway
Columbia, Missouri 65218-0001

INDIVIDUAL LIFE INSURANCE APPLICATION

Agent Name:

Agent #:

Agent Phone #:

Family #:

Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. Country of Citizenship: Length of Residency in US:
   Visa Type: Category: Expiration Date:
7. Occupation: Name of Employer: Date Employed:
8. Annual Earned Income: Income All Sources:

Coverage Information

9. Plan: Face Amount: $ Rate Class:
10. Waiver of Premium: Accidental Death: Amount: $
11. Mode Premium: $ Mode of Premium: Premium included with application: $
11a. Remarks:

Information for Other Involved Parties

12. Primary Beneficiary:

    Contingent Beneficiary:

    Payor:

    Owner:

    Successor Owner:

Existing Insurance Information

13. Total individual life insurance and accidental death coverage in force or pending (excluding this application):

	(Life)	(Accidental Death)
With Shelter Life:	$	$
With Other Companies:	$	$

13a. Amount of life insurance on: Father: Mother: Sibling #1: Sibling #2:
Sibling #3: Sibling #4: Sibling #5: Sibling #6: Sibling #7:

14a. Do you have existing life insurance policies or contracts? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.29 with this application.

14b. Will this application replace an existing policy or contract? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.33 with this application.

Proposed Insured Name: Application Number:

Underwriting Information

15. Have you ever seen a doctor? Yes ☐ No ☐

Please provide the following information for your most recent doctor consultation(s):

Hospital or clinic: Date of last consultation:
Physician's name: Reason for last consultation:
Street address: Diagnosis:
City, State, Zip: Treatment:
Phone Number: Medication(s) prescribed:
Fax Number:

16. Do you have a parent or sibling who has a history of diabetes, heart or kidney disease, or hypertension? Yes ☐ No ☐
Relationship to Insured**:** Explanation:

17. Do you have a parent or sibling who died before age 60? Yes ☐ No ☐
Relationship to Insured: Age at death:
Explanation:

18. Have you engaged in or do you anticipate engaging in:
a) Aviation activities, including ultralight flying, hang gliding or parachute jumping? Yes ☐ No ☐

b) Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby? Yes ☐ No ☐

19. In the past 5 years have you been charged with any motor vehicle violations or violations for driving while intoxicated from alcohol or drugs? Yes ☐ No ☐
Violation Date: Description:

20. Are you planning travel, residence, or employment outside the United States? Yes ☐ No ☐
Travel Dates: Description:

21. Do you now use or have you ever used any form of tobacco or nicotine substitutes? Yes ☐ No ☐
Date last used: Details:

22. Are you in the National Guard or Reserves? Yes ☐ No ☐
Details:

23. Have you been charged with any misdemeanor or felony? Yes ☐ No ☐
Date of crime: Type of offense:
Were you convicted? Description:

Medical Information

Questions in the Medical Information section (questions 24-41) may be left unanswered if a medical exam is required.

24. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease or disorder of the heart or blood vessels? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

25. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for cancer, tumor or other growth or malignancy of any kind? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Medical Information Continued

26. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

27. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for depression, anxiety or any other behavioral, mental or nervous disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

28. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

29. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

30. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

31. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

32. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Medical Information Continued

34. Are you now pregnant? Yes ☐ No ☐
    Approximate Delivery Date:
    Description of pregnancy and any medical attention received:

    Treating hospital(s) and/or physician(s):

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

36. Have you had weight loss of more than 10 lbs. in the past year? Yes ☐ No ☐
    Date: Number of pounds lost:
    Reason for and details of weight loss:

    Treating hospital(s) and/or physician(s):

37. Have you used or do you now use cocaine, methamphetamines, marijuana or any other drugs? Yes ☐ No ☐
    Date last used: Length of drug use:
    Amount: Frequency:
    Drug type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

38. Have you used or do you now use alcoholic beverages? Yes ☐ No ☐
    Date of last drink: Frequency:
    Amount: Alcohol type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

39. Have you sought or received treatment or counseling for alcohol or drug use? Yes ☐ No ☐
    Date of treatment: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

40. Have you received or do you now receive disability benefits or do you currently have a disability of any kind? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

41. In the past 5 years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Special Requests

42.

Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and
(2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER Yes ☐ No ☐

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Dated this _____ day of _____ (Month) _____ (Year) at _____ (Time) ☐ A.M. ☐ P.M. in the city of_____ State of _____

_____
Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

_____
Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

_____
Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

_____ Print Name of Writing Agent

_____ Signature of Writing Agent

_____ Agent's Number

Medical Test Authorization

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid, or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies, and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date	Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

Conditional Coverage Receipt

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $_____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount $_____

by _____ _____ _____
Signature of Writing Agent | Agent's Number | Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

PAYMENT BY CREDIT OR DEBIT CARD - Payment will be charged to your card on the date and time of the application. If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned by company check.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

SERFF Tracking Number:	*SHLI-126754984*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*46397*
Company Tracking Number:	*03L10110*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Level Term Application*		
Project Name/Number:	*E-app/L10110*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR Flesch Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
L-953.pdf

SHELTER INSURANCE COMPANIES

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores. They do not comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act, due to required wording.

Form No.	Name	Score
L-953	Individual Life Insurance Application	51.2

Signed Robert W Omdal

Digitally signed by Robert W Omdal
DN: cn=Robert W Omdal, o, ou, email=romdal@shelterinsurance.com, c=US
Date: 2010.08.04 12:49:01 -05'00'

Robert W. Omdal, FSA, MAAA
Chief Actuary – Life and Health
Shelter Life Insurance Company

SHELTER LIFE INSURANCE COMPANY

1817 West Broadway
Columbia, Missouri 65218-0001

INDIVIDUAL LIFE INSURANCE APPLICATION

Agent Name:

Agent #:

Agent Phone #:

Family #:

Personal Information

1. Name: Gender: SSN: Marital Status:
2. Birth Date: Age: Height: Weight: Place of Birth:
3. Physical Address: County:
3a. Mailing Address: County:
4. Home Phone: Cell Phone: Best Time to Contact:
5. Driver's License Number: State:
6. Country of Citizenship: Length of Residency in US:
   Visa Type: Category: Expiration Date:
7. Occupation: Name of Employer: Date Employed:
8. Annual Earned Income: Income All Sources:

Coverage Information

9. Plan: Face Amount: $ Rate Class:
10. Waiver of Premium: Accidental Death: Amount: $
11. Mode Premium: $ Mode of Premium: Premium included with application: $
11a. Remarks:

Information for Other Involved Parties

12. Primary Beneficiary:

    Contingent Beneficiary:

    Payor:

    Owner:

    Successor Owner:

Existing Insurance Information

13. Total individual life insurance and accidental death coverage in force or pending (excluding this application):

	(Life)	(Accidental Death)
With Shelter Life:	$	$
With Other Companies:	$	$

13a. Amount of life insurance on: Father: Mother: Sibling #1: Sibling #2:
Sibling #3: Sibling #4: Sibling #5: Sibling #6: Sibling #7:

14a. Do you have existing life insurance policies or contracts? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.29 with this application.

14b. Will this application replace an existing policy or contract? ☐ Yes ☐ No
If yes, please send Replacement Form L-243.33 with this application.

Proposed Insured Name: Application Number:

Underwriting Information

15. Have you ever seen a doctor? Yes ☐ No ☐

Please provide the following information for your most recent doctor consultation(s):

Hospital or clinic: Date of last consultation:
Physician's name: Reason for last consultation:
Street address: Diagnosis:
City, State, Zip: Treatment:
Phone Number: Medication(s) prescribed:
Fax Number:

16. Do you have a parent or sibling who has a history of diabetes, heart or kidney disease, or hypertension? Yes ☐ No ☐
Relationship to Insured**:** Explanation:

17. Do you have a parent or sibling who died before age 60? Yes ☐ No ☐
Relationship to Insured: Age at death:
Explanation:

18. Have you engaged in or do you anticipate engaging in:
a) Aviation activities, including ultralight flying, hang gliding or parachute jumping? Yes ☐ No ☐

b) Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby? Yes ☐ No ☐

19. In the past 5 years have you been charged with any motor vehicle violations or violations for driving while intoxicated from alcohol or drugs? Yes ☐ No ☐
Violation Date: Description:

20. Are you planning travel, residence, or employment outside the United States? Yes ☐ No ☐
Travel Dates: Description:

21. Do you now use or have you ever used any form of tobacco or nicotine substitutes? Yes ☐ No ☐
Date last used: Details:

22. Are you in the National Guard or Reserves? Yes ☐ No ☐
Details:

23. Have you been charged with any misdemeanor or felony? Yes ☐ No ☐
Date of crime: Type of offense:
Were you convicted? Description:

Medical Information

Questions in the Medical Information section (questions 24-41) may be left unanswered if a medical exam is required.

24. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease or disorder of the heart or blood vessels? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

25. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for cancer, tumor or other growth or malignancy of any kind? Yes ☐ No ☐
Date of onset: Duration:
Description of illness or injury, medical attention received, remaining effects, and any other details:

Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Medical Information Continued

26. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

27. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for depression, anxiety or any other behavioral, mental or nervous disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

28. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

29. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

30. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

31. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

32. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Medical Information Continued

34. Are you now pregnant? Yes ☐ No ☐
    Approximate Delivery Date:
    Description of pregnancy and any medical attention received:

    Treating hospital(s) and/or physician(s):

35. Are you currently receiving treatment, taking medication, or scheduled to have surgery? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

36. Have you had weight loss of more than 10 lbs. in the past year? Yes ☐ No ☐
    Date: Number of pounds lost:
    Reason for and details of weight loss:

    Treating hospital(s) and/or physician(s):

37. Have you used or do you now use cocaine, methamphetamines, marijuana or any other drugs? Yes ☐ No ☐
    Date last used: Length of drug use:
    Amount: Frequency:
    Drug type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

38. Have you used or do you now use alcoholic beverages? Yes ☐ No ☐
    Date of last drink: Frequency:
    Amount: Alcohol type(s):
    Details including any remaining effects:

    Treating hospital(s) and/or physician(s):

39. Have you sought or received treatment or counseling for alcohol or drug use? Yes ☐ No ☐
    Date of treatment: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

40. Have you received or do you now receive disability benefits or do you currently have a disability of any kind? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

41. In the past 5 years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above? Yes ☐ No ☐
    Date of onset: Duration:
    Description of illness or injury, medical attention received, remaining effects, and any other details:

    Treating hospital(s) and/or physician(s):

Proposed Insured Name: Application Number:

Special Requests

42.

Signatures/Declaration

The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:
(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and
(2) to the best of the Owner's and Proposed Insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER Yes ☐ No ☐

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Dated this _____ day of _____ (Month) _____ (Year) at _____ (Time) ☐ A.M. ☐ P.M. in the city of_____ State of _____

_____
Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

_____
Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

_____
Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

_____ Print Name of Writing Agent

_____ Signature of Writing Agent

_____ Agent's Number

Medical Test Authorization

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid, or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies, and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

Date	Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

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Premium received from _____ Amount $_____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For _____ Face Amount $_____

by _____ _____ _____
Signature of Writing Agent | Agent's Number | Date

ALL PREMIUM CHECKS MUST BE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

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CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive; (2) to the best of your knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

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when application is written.

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